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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

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BOARD OF MEDICAL PRACTICE

Physician Self Report Form

Your duty of self-reporting as required by 24 Del C., § 1731A is not complete until this form has been returned to the Board. This form may be duplicated.

____
Name of Physician License No. Office Telephone No.

____
Address City State Zip

Malpractice Complaint: (Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.)

Plaintiff's Name: ______________________________________Age:________Sex:______________

Address of Record: ____

Date/Place of Occurrence: ____

Indicate your position in case, i.e., resident, primary physician, etc: ______________________________________

____

Filed Against: (   ) Individual Doctor (   ) Group (   ) Hospital

List names of other defendant-doctors and/or hospitals: ____

Disposition: (   ) Verdict (   ) Settled

Please provide the following information related to the verdict or settlement:

Civil Case No.: ______________________Legal Attorney: ___________________________________

Final Disposition: ____

Date of Disposition: _____________________Total Amount Paid (if any): __________________________

Insurance company covering you for this incident:____

Amount attributable to you: ____

YOU MAY PROVIDE A DETAILED EXPLANATION OF THE MEDICAL ISSUES INVOLVED IN THE REFERENCED LITIGATION.

Signature: ____Date: __________________________________